Revision: HCFA-PM-91-10 (MB)
December 1991

OFFICIAL

State/Territory: New Jersey

Citation 4.14 Utilization/Quality Control (Continued)

42 CFR 438.356(e)	For each contract, the State must follow an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR part 74 as it applies to State procurement of Medicaid services.
42 CFR 438.354 42 CFR 438.356(b) & (d)	The State ensures that an External Quality Review Organization, and its subcontractors performing the External Quality Review or External Quality Review-related activities, meet the competence and independence requirements.
___	Not applicable.

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Revision: HCFA-AT-91-4(BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: New Jersey

Citation		
42 CFR 447.51 through 447.58	(a)	Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.
1916(a) and (b) of the Act	(b)	Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

4.18 Recipient Cost Sharing and Similar Charges

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

[ ] Age 19

[ ] Age 20

[X] Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

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AUGUST 1991

State/Territory: New Jersey

Citation 4.18(b)(2) (Continued)

42 CFR 447.51 through 447.58

(iii) All services furnished to pregnant women.

Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a managed care organization, health insuring organization, prepaid inpatient health plan, or prepaid ambulatory health plan in which the individual is enrolled, unless they meet the requirements of 42 CFR 447.60.

42 CFR 438.108
42 CFR 447.60

[ ] Managed care enrollees are charged deductibles, coinsurance rates, and copayments in an amount equal to the State Plan service cost-sharing.

[X] Managed care enrollees are not charged deductibles, coinsurance rates, and copayments.

1916 of the Act, P.L. 99-272, (Section 9505)

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

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Revision: HCFA-AT-84-2 (BERC)
01-84

OFFICIAL

State/Territory: New Jersey

Citation	4.23	Use of Contracts
42 CFR 434.4 48 FR 54013		The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.
		/_/ Not applicable. The State has no such contracts.
42 CFR Part 438		The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 438. All contracts meet the requirements of 42 CFR Part 438. Risk contracts are procured through an open procurement process that is consistent with 45 CFR Part 74. The State does not use a competitive bid process, but contracts with any willing and qualified provider that meets the State's contract standards for managed care organizations. The risk contract is with (check all that apply):
		_X_ a Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2
		___ a Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2
		___ a Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2.
		___ Not applicable.

TN # 03-07
Supersedes TN # 84-05

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New: HCFA-PM-99-3
JUNE 1999

State: New Jersey

Citation

1902(a)(4)(C) of the Social Security Act P.L. 105-33	4.29 Conflict of Interest Provisions The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the prohibition against acts, with respect to any activity under the plan, that are prohibited by section 207 or 208 of title 18, United States Code.
1902(a)(4)(D) of the Social Security Act P.L. 105-33 1932(d)(3) 42 CFR 438.58	The Medicaid agency meets the requirements of 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

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Revision: HCFA-AT-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193
4.30 continued

State/Territory: New Jersey

Citation		
	(b)	The Medicaid agency meets the requirements of –
1902(p) of the Act		(1) Section 1902(p) of the Act by excluding from participation—
		(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).
42 CFR 438.808		(B) Any MCO (as defined in section 1903(m) of the Act), or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that –
		(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or
		(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.
1932(d)(1) 42 CFR 438.610		(2) An MCO, PIHP, PAHP, or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438.610(b)) who are suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549. If the State finds that an MCO, PCCM, PIHP, or PAHP is not in compliance, the State will comply with the requirements of 42 CFR 438.610(c)

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State/Territory: New Jersey

Citation
1902(a)(39) of the Act

(3) Section 1902(a)(39) of the Act by —

(A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and
(B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

(c) The Medicaid agency meets the requirements of__

(1) Section 1902(a)(41) of the Act with respect to prompt notification to CMS whenever a provider is terminated, suspended, sanctioned or otherwise excluded from participating under this State plan; and
(2) Section 1902 (a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

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State: New Jersey

Agency*	Citation(s)		Groups Covered
		B.	Optional Groups Other Than the Medically Needy (Continued)
42 CFR 435.212 & 1902(e)(2) of the Act, P.L. 99-272 (section 9517) P.L. 101-508(section 4732)	X	3.	The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO), or a primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.

___ The State elects not to guarantee eligibility.

X The State elects to guarantee eligibility. The minimum enrollment period is 6 months (not to exceed six).

The State measures the minimum enrollment period from:

___ The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.

X The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

___ The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

*Agency that determines eligibility for coverage.

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Agency* Citation(s) Groups Covered

B. **Optional Groups Other Than Medically Needy** (continued)

1932(a)(4) of Act

The Medicaid Agency may elect to restrict the disenrollment rights of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56 .
This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

__X__ Disenrollment rights are restricted for a period of __12__ months (not to exceed 12 months).

During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

__X__ No restrictions upon disenrollment rights for SSI and Aged, Blind and Disabled Groups.

1903(m)(2)(H), 1902(a)(52) of the Act P.L. 101-508 42 CFR 438.56(g)

In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.

__X__ The agency elects to reenroll the above individuals who are ineligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.

___ The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

- Agency that determines eligibility for coverage.

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Mandatory Enrollment into Managed Care

State: New Jersey

Citation	Condition or Requirement

1932 (a)(1)(A) A. Section 1932 (a)(1)(A) of the Social Security Act.

The State of New Jersey enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (i.e. managed care organization (MCOs) in the absence of section 1115 or section 1915 (b) waiver authority. This authority is granted under section 1932 (a)(1)(A) of the Social Security Act (the Act). Under this authority, New Jersey has amended its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority is not used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), or to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet eligible certain categories of "special needs" beneficiaries (see D.2.i.-vii.)

B. General Description of the Program and Public Process.

1932 (a)(1)(B)(i)
1932 (a)(1)(B)(ii)
42 CFR 438.50 (b)(1)

1. The State contracts with managed care organizations, on a comprehensive risk basis.

42 CFR 438.50 (b)(2)
42 CFR 438.50 (b)(3)

2. The payment method utilized by the State is capitation.

42 CFR 438.50 (b)(4)

3. The general public process utilized by the State for both the design of the New Jersey Care 2000+ managed care program and its initial implementation was conducted over a period of five years, with input from consumers, advocates, providers and HMOs. All of these entities continue to have input through various meetings and committees. The general public process utilized by the State for subsequent amendments to the New Jersey Care 2000+ program is as follows: State of New Jersey regulatory process; notification of state plan amendments in the newspapers of widest circulation in cities of 50,000 or more within the State; posting at the 21 county Boards of Social Services; posting at the Medical Assistance Customer Centers; and discussion at the meetings of the Medical Assistance Advisory Council. The state will also use the following methods to ensure ongoing public involvement: surveys of consumers; public posting of contract provisions on the state's web site; State regulatory process; regular meetings with a managed care advisory group; and presentation of managed care issues at the quarterly meetings of the Medical Assistance Advisory Council.

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